Nuvance Health

External Referral Form for:

COVID-19 Recovery Program at Nuvance Health

1. Does the patient have a documented positive COVID-19 PCR test?
   (please fax results with this form)
2. Is the patient 18 years or older?
3. Has the patient had symptoms for 3 months or more since onset of COVID 19?
4. Does the patient still have lingering symptoms of COVID 19?
   If so please describe _____

Complete this form and fax it with a copy of the positive COVID-19 PCR test result report, current medication list & fax cover sheet to fax # (203) 739-8965

Patient Name, Age, DOB _____

Past Medical History _____

Referring provider name _____

Referring provider phone number _____

Name of practice where referral is coming from _____